Questions and answers in advance of 4/19/13 Complex Care Committee Q&A call

Matt Katz:

1. Why does the state have an estimated increase of staffing expense of 3% for itself (its employees) and the contractor employees but only a 2% cost increase in year two from base year for the network neighborhood staffing? Why is the state staffing increase higher? *The increase in year two for state staffing is in error. Those costs should be held constant over the funding period.*

2. Why is there a 38% fringe built into state and contractor staffing but only salary into the HN staffing? *Fringe for the state positions is based on current fringe allocation. Fringe is not included in the HN Administration line because this is a contract payment to the HNs that can be used within contract guidelines as needed to support administrative oversight. Fringe is not included in the contractual lines because these estimates include the entire costs of performing the service in question.*

3. Also, 38% seems extremely high for fringe- most grants we receive limit it to 10 or 15% and most standard fringe calculations are closer to 25 or 30%- why so high? *This fringe rate is not high by current state standards.*

4. I am very surprised at the expense of the HER swipe card technology vendor- who is the state using and has this gone out to bid? *The state anticipates using a sole source contract for this service. We may be able to negotiate a more favorable price. Cost estimates describe the outside range of expenses.*

5. What is Xerox doing for the member enrollment, isn't some of the enrollment part of the HN and other staffing contracting support- this amount also seems high in base year (year two seems appropriate) *Xerox has since submission of the initial application been identified as the contractor through which the HN passive enrollment process will occur. CHN-CT will forward lists of beneficiaries to be enrolled in HN on the basis of affiliation with a HN primary care provider, and Xerox will then issue the welcome/informational packets, will work with identified existing sources of care coordination (e.g. waiver care managers, LMHA case managers, and MFP transition coordinators) to support enrollment of individuals served by those sources, will support all HN participants in enrollment counseling as well as inventorying their choice of Lead Care Manager, and will collect and document all instances in which a beneficiary opts out of participation in a HN. Xerox's work includes modification of their enrollment system in order to allow client enrollment in the Demo and communicate that information as needed (for example, to the MMIS for claims purposes).*

6. For marketing materials, are these truly only the mailing costs, what about development (design) and printing costs? *This figure is our best available estimate of total costs.*

7. What is the design Assistance for HNs year one- is this a clinical staff, administrative staff, coordinator? *As we have previously discussed with the Committee, the design assistance is intended to support the HNs in forming (e.g. connecting providers across disciplines, use of care coordination contracts, etc.).*

8. So, we are now assuming 5 actual HNs? I ask because previous documents spoke of up to 5 but more likely to be 3 to start? *We have budgeted for 5 but are continuing to reinforce that the State will contract with 3 -5.*

9. I don't see any funding included for monitoring and coordination (further use of the CCC or other state committee) or is this funded separately through the state? Wouldn't we want some of the oversight, review and monitoring built in from a funding perspective? *Program oversight and monitoring is a key activity to be performed by the Department staff identified in the application. Additionally, some of this function would be performed by the performance evaluation contractor.*

Alicia Woodsby:

My question for the conference call on Friday is whether or not support for the supplemental services is included in the PMPM calculation, and if not, how these services will be funded.

In the budget, supplemental services are included in the implementation funds request, and not in the APM 2 (pmpm payment for care coordination to LCMAs). The budget summary page lists the line item of funding for supplemental services to be provided to each HN. The derivation of these was based on the following (for a full year of client enrollment):

	Total Clients	***Percent in Need***	***Clients in Need***	***Annual Case Load***	***Fully Loaded Staff Cost***	***# Staff Needed***	***Annual Cost***
Nutrition Counseling	*20,000*	*10%*	*2,000*	*3,000*	*$75,000*	*0.67*	*$50,000*
Falls Prevention	*20,000*	*10%*	*2,000*	*3,000*	*$50,000*	*0.67*	*$33,333*
Chronic Disease Self-Education	*20,000*	*20%*	*4,000*	*3,000*	*$50,000*	*1.33*	*$66,667*
Medication Therapy Management	*20,000*	*20%*	*4,000*	*1,500*	*$75,000*	*2.67*	*$200,000*
Peer Support	*20,000*	*20%*	*4,000*	*1,500*	*$50,000*	*2.67*	*$133,333*
Recovery Assistance	*20,000*	*20%*	*4,000*	*1,500*	*$50,000*	*2.67*	*$133,333*
						10.67	*$616,667*

Total Expenditure (per HN)	***$ 123,333***

Quincy Abbot:

The submission draft is well written and clear. However, I do have a few comments.

Page 4. Each MME in an HN can select a LCMA and a LCM within the agency. Consider the situation of a DDS waiver individual with a DDS case manager and a nurse currently overseeing medical services within the provider agency. Can the MME select DDS as the LCMA and the DDS case manager as the LCM – essentially continuing the system that is working for the individual today?
A person may select his or her DDS care manager as an LCMA and receive all of his/her care coordination via DDS. All LCMAs/LCMs will be responsible for the activities and scope required under the Demonstration. DDS will not be eligible to receive APM II or shared savings payments.

Page 5.Standard Care Coordination Agreements. Since individuals may select some providers outside of the HN, how can/will case coordination exist and be enforced with those outside providers?
Outreach to and education of providers outside of the Health Neighborhoods will be a key activity for the HNs and for DSS. You are correct that a client may see providers outside the HN, which would not have signed on to the HN care coordination agreement. However, LCMs will outreach to all providers as needed and work to coordinate care. Additionally, the CHNCT provider portal and integrated Medicare-Medicaid claims data will enable HN providers to identify utilization at other providers and perform follow up and coordination as needed.

Cost estimation. Individuals with intellectual disabilities or other cognitive issues may be more costly because of the difficulties in communicating with them both at the LCM and provider levels. A big problem today exists today for those served by DDS in finding medical providers who have the skill and time for this communication. For example, physicians, hospitals, and nursing homes generally have no training or funding to spend the additional time required for communication. At the very least this factor should be reflected in the "severity level." If the LCM is an RN or LPN, they may need special training and/or a lower caseload to case manage such individuals.
The predictive modeling to determine risk levels takes account of a wide variety of diagnoses and care needs. Additionally, the LCM will perform an individualized assessment to determine the level of care coordination needed by the individual, and address care barriers in the Plan of Care. Attending to the barriers to care for individuals with intellectual disabilities is a priority in the Demonstration, and some of the priority areas for provider training include person-centeredness, disability culture, and strategies for engaging with individuals with intellectual disabilities.

Jill Benson:

1. In the overall budget, the marketing amount appears to be minimal. This is a new effort and will be confusing to individuals. *The budget figure is the best current estimate of these expenses based on the Department's experience with outreach on new initiatives.*

2. The APM II payments aren't reflected in the overall Health Neighborhood budget total costs *The budget does not depict the APM II payments as part of overall HN budgets because those payments will be made directly to Lead Care Management Agencies, and are not part of this request for implementation funding.*

3. There are more dollars being allocated to external contractors with administrative roles than to Health Neighborhoods, who will actually be providing the services *The contractual lines reflect essential features that will support the work of the HNs, including HN formation, enrollment, reimbursement, marketing and evaluation. Additionally, as above, the main payments made to support care coordination by HNs (APM 2 payments) are not reflected in this budget as they are not part of the implementation funds request.*

4. There are more dollars allocated to CHN-Model 1, than Health Neighborhoods- for CHN this is an enhancement to an already established infrastructure. With the Health Neighborhoods, you are creating a new concept and going into unchartered waters, needing to build from the ground up. *In addition to providing tailored care coordination for MMEs who are participating in Model 1, CHNCT will be modifying its predictive modeling tools in support of identifying stratifying the needs of individuals served by HNs, managing integrated Medicare and Medicaid data, performing member services support for all MMEs and providing data through its provider portal to HN provider members. Additionally, the main payments made to support care coordination by HNs (APM 2 payments) are not reflected in this budget as they are not part of the implementation funds request.*

5. Can you mention (to the committee) the contractors you will use in sole source contracts? *No, the contract process does not permit this.*

Regarding APM II and care coordination:

1. Cost estimates for staff do not include LCSW's , which in previous discussions were included as one of the credentials *We acknowledge this point and will review the analysis on that basis.*

2. Dollars budgeted only include salary and benefits and do not include other related costs (i.e. if face to face service is part of model design, there needs to be consideration of travel costs) *It is our assumption that MMEs will choose HN participating LCMs who are local to them, reducing travel costs.*

3. Original model proposed 3 levels of care coordination. Please explain rationale for changing and how ratios were determined. *The five listed levels relate to APM II reimbursement. Related, the application narrative describes three broad categories of the types of support that can be provided by LCMs over those levels of acuity.*

a. If 38% of this population has serious mental illness, then these ratios appear to be too low, particularly in the higher level intensive need levels. *We will consider this point.*

b. If determination is made from primary care claims data, the SMI population will be underrepresented. *The predictive modeling algorithms take into account a range of claims data and we will be tailoring this method for use under the Demonstration taking this comment and other similar comments into account.*